TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
FONDREN OTHROPEDIC GROUP, LLP

Respondent Name
TRUMBULL INSURANCE CO

MFDR Tracking Number
M4-17-0694-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
NOVEMBER 10, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "we have attached the medical notes support the charges we billed and are asking that you send the claim back for reprocessing and issue the provider the payment we are due for this code."

Amount in Dispute: $99.02

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Injection procedure not was not in documentation submitted by the provider for CPT 20610 and and [sic] j code, thus remains denied."

Response Submitted By: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 15, 2016	CPT Code 20610	$92.83	$0.00
	HCPCS Code J1030	$6.19	$0.00
TOTAL		$99.02	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. 28 Texas Administrative Code §134.1, effective March 1, 2008, requires in the absence of an applicable fee guideline, medical reimbursement shall be fair and reasonable.
4. The services in dispute were reduced/denied by the respondent with the following reason code:
    - B12-Services not documented in patients medical records.
    - 112-Billed service is not identified in the Operative Report.

- W3-Additional payment made on appeal/reconsideration.
- 275-The charge was disallowed; as the submitted report does not substantiate the service being billed.

Issues

Does the documentation support billing CPT codes 20610 and J1030? Is the requestor entitled to reimbursement?

Findings

According to the explanation of benefits, the respondent denied reimbursement for codes 20610 and J1030 based upon service not being documented in the medical records.

28 Texas Administrative Code §134.203(b) states "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers…"

CPT code 20610 is defined as "Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); without ultrasound guidance. "

HCPCS code J1030 is defined as "Injection, methylprednisolone acetate, 40 mg."

A review of the Operative Report does not document or support billing CPT code 20610 or J1030; therefore, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		12/8/2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.